Patient and Family Engagement

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Lodi Health

Lodi Health

Lodi Health: a non-profit health system which includes an inpatient hospital, emergency department, and several medical practices.

Average daily census is 86 patients.

Lodi Health operates primary-care, multi-specialty, OB, pediatric, wound care and occupational health practices.

2010 Lodi Health Strategic Plan

Assigned management level task forces:

Readmission Prevention Patient Satisfaction

Leadership education re: changes in health care

Culture change: Not an automatic process!

Shift: Getting the patient out vs. successful transition

"Do we have to do everything for these patients?"

Walking through the process with patients

One step at a time Structure Commitment Communication Flexibility

Patience: Each change brings culture change along

2011

Strong customer service focus

- AIDET: Acknowledge, Introduce, Duration, Explain, Thank
- Managing up
- Words that work
- Leadership rounding
- **Gradual changes: attitudes, personalities, approaches, habits**

Readmission Prevention Planning: Project BOOST

- High-risk assessment
- Passport to Care
- Teach back
- Follow-up phone calls
- **Gradual changes: Revisions, Trial and assess, creativity**

Patient Family Engagement

Patient Family Engagement

Transition Social Work: Frequent admissions/ED visits/self-pay

Emergency Department Case Management:

- Patient Engagement on the front end: Readmissions Level of care

2012

Readmission prevention: hospital wide

Initiated the Patient Discharge Advocate Position

- Not nurses or social workers
- Coordinate discharge planning
- Strong patient/family contact component
- Requires the right person: Fast paced People oriented Customer service

Revised case management floor model

- One RN case manager per floor (ratio 1:30)
- Two patient discharge advocates (ratio 1:15)
- Social worker assigned

Patient engagement requires strong team work

Patient Family Engagement: Community

Cross Setting Work Group: Skilled Nursing Facility (SNF) meetings

- Communication improvement: Both sides
  - Standardize communication to patients/families between settings
  - Transition flows better for patients/families
  - Handoff
- SNF staff training to respond to patients/families: Change in condition
- Advanced Health Care Directives: Social Work Community Outreach
- POLST Process (Physician Order for Life Sustaining Treatment)
  - More conversations re: this on the acute care and SNF sides

2013

Patient Discharge Advocates: follow-up phone calls

- Ensure patients/families understand their plan and importance of follow-up
- Determine barriers to a positive transition
  - Coordinate intervention from RN case management or social work

Case Manager Readmission Assessment

- Conversation with the patient/family

Lodi Health Medical Practices: Planning for transition patient follow-up

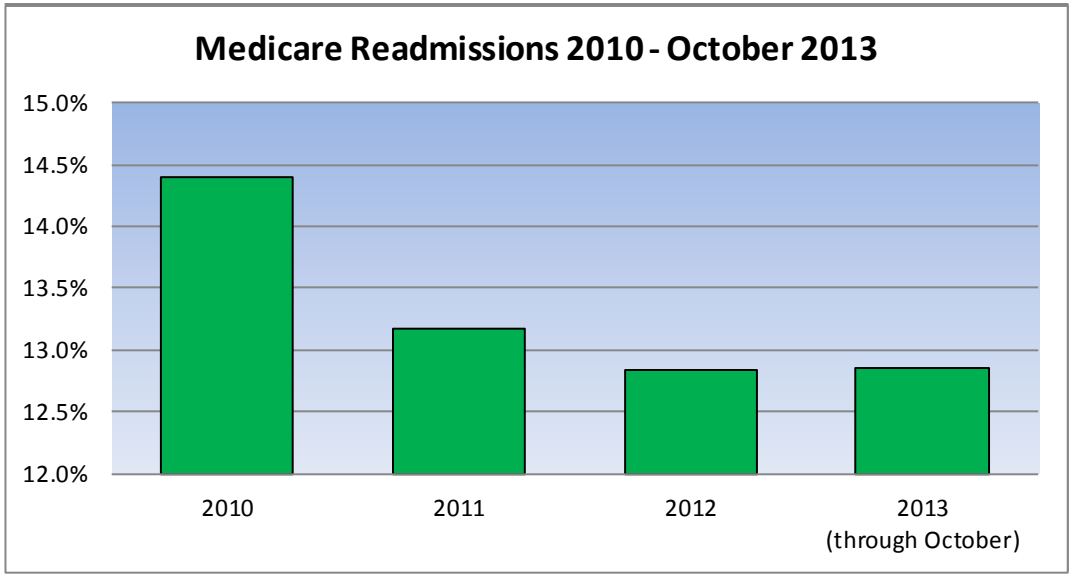
- Transition billing criteria:
  - Follow-up phone call completion Medication reconciliation Physician office visit
- Pharmacy involvement
  - Medical practices Hospital: high-risk inpatient/families

Home Health/LH Community Partnership Group

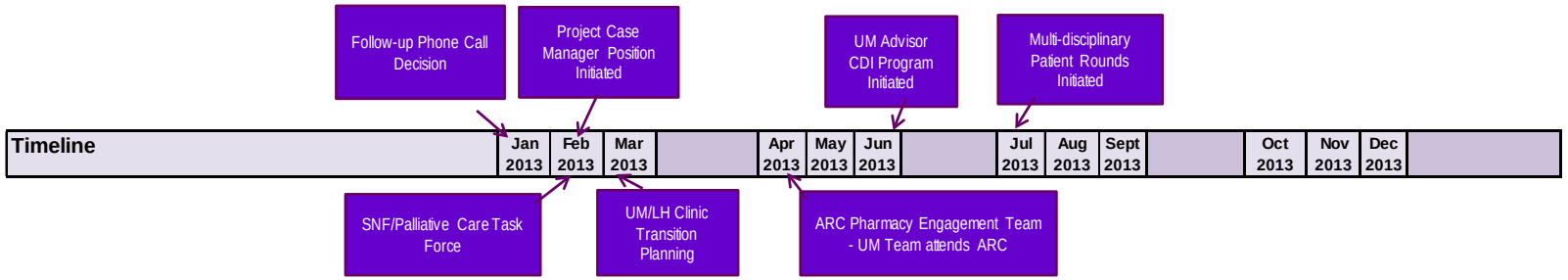
Readmission Picture 2010-2013

Medicare Readmissions 2010 - October 2013

2010	2011	2012	2013 (through October)
14.39%	13.17%	12.84%	12.86%



All-Cause Readmissions 2013



Indicator	Benchmark (BM)	Jan 2013	Feb 2013	Mar 2013	Q1 2013	Q1 BM	Apr 2013	May 2013	Jun 2013	Q2 2013	Q2 BM	Jul 2013	Aug 2013	Sept 2013	Q3 2013	Q3 BM	Oct 2013	Nov 2013	Dec 2013	Q4 2013	Q4 BM	2013 To Date
MS-DRG Acute Care Case Mix Index (CMI)	1.41	1.35	1.32	1.24	1.30	1.40	1.31	1.26	1.32	1.30	1.42	1.27	1.28	1.28	1.28	1.44	1.31	1.33	1.29	1.31	1.40	1.30
MS-DRG Acute Care Case Mix Index Medicare	1.46	1.41	1.34	1.27	1.34	1.45	1.21	1.29	1.29	1.26	1.44	1.30	1.38	1.29	1.32	1.50	1.38	1.35	1.36	1.36	1.47	1.32
Acute Care Discharge Volume	5096	510	467	501	1478	1468	407	463	433	1303	1300	454	489	425	1368	1125	430	402	461	1293	1203	5442

Indicator	Benchmark (BM)	Jan 2013	Feb 2013	Mar 2013	Q1 2013	Q1 BM	Apr 2013	May 2013	Jun 2013	Q2 2013	Q2 BM	Jul 2013	Aug 2013	Sept 2013	Q3 2013	Q3 BM	Oct 2013	Nov 2013	Dec 2013	Q4 2013	Q4 BM	2013 To Date
Acute Care Arithmetic Mean LOS	5.05	5.26	5.38	4.65	5.10	5.26	5.03	4.97	5.08	5.03	5.16	6.2	5.17	5.04	5.47	4.86	5.17	5.34	5.18	5.23	4.88	5.21
Acute Care Geometric Mean LOS	3.80	3.95	4	3.55	3.83	3.9	3.78	3.79	3.84	3.80	3.91	4	3.77	3.7	3.82	3.63	3.78	3.93	3.89	3.87	3.78	3.83
Acute Care %Readmit within 30 Days	11.22	12.3	15.74	12.17	13.40	12.6	11.77	12.17	13.27	12.40	10.6	12	14.1	12.4	12.8	9.44	11.68	15.05	13.6	13.46	11.9	13.02
Acute Care %Readmit within 14 Days	6.10	6.15	8.43	7.01	7.20	6.79	7.42	7.08	7.58	7.36	5.6	7.24	7.58	7.04	7.29	5.62	6.43	8.42	7.5	7.45	6.25	7.32
Acute Care %Readmit within 7 Days	3.48	3.69	5.54	3.71	4.31	4.08	4.35	2.88	4.27	3.83	2.96	4.3	5.26	4.13	4.56	3.21	3.81	5.1	4.55	4.49	3.58	4.30
Acute Care Medicare %Readmit within 30 Days	12.64	12.2	18.07	12.82	14.35	15.3	12.74	12.80	13.50	13.01	12.4	11.5	14.34	9.21	11.7	10.5	12.19	15.1	13.7	13.65	11.7	13.18
Acute Care Medicare %Readmit within 14 Days	6.79	4.18	9.24	7.33	6.92	8.58	7.84	6.00	7.17	7.00	6.47	7.41	8.61	3.95	6.66	6.26	7.14	8.89	7.63	7.89	5.39	7.12
Acute Care Medicare %Readmit within 7 Days	3.74	1.52	6.02	4.03	3.86	5.12	5.39	2.80	4.64	4.28	3.09	4.94	5.74	3.51	4.73	3.6	3.78	5.33	4.02	4.38	2.85	4.31

Indicator	2012	Q1 2012	Q2 2012	Q3 2012	Q4 2012
MS-DRG Acute Care Case Mix Index	1.41	1.40	1.42	1.44	1.40
MS-DRG Acute CMI Medicare	1.46	1.45	1.44	1.50	1.47
Acute Care Discharge Volume	5096	1468	1300	1125	1203

***Benchmarks:**

LMH Data for 2012 Reduced 3% (CMI and Discharge Volume are Not Reduced)

Exclusion criteria

- *SERVICES (#2), LOCATIONS (#5), or ENCOUNTER TYPE (#505) Dictionary entry equivalent to rehabilitation, behavioral health, skilled nursing, or hospice*
- *Inpatient delivery encounters with ICD-9 V codes V27.0–V27.9*
- *Inpatient newborn encounters with ICD-9 V codes V30.00–V39.01*
- *Length of stay longer than 365 days or not specified*

Readmissions are 'all cause' and exclude elective readmits - expired patients are excluded from the index population

Indicator	2012	Q1 2012	Q2 2012	Q3 2012	Q4 2012
Acute Care Arithmetic Mean LOS	5.21	5.42	5.32	5.01	5.03
Acute Care Geometric Mean LOS	3.92	4.02	4.03	3.74	3.9
Acute Care %Readmit within 30 Days	11.57	13	10.9	9.73	12.29
Acute Care %Readmit within 14 Days	6.29	7	5.77	5.79	6.44
Acute Care %Readmit within 7 Days	3.59	4.21	3.05	3.31	3.69
Acute Care Medicare %Readmit - 30 Days	13.03	15.7	12.8	10.8	12.06
Acute Care Medicare %Readmit - 14 Days	7.00	8.85	6.67	6.45	5.56
Acute Care Medicare %Readmit - 7 Days	3.86	5.28	3.19	3.71	2.94

No Easy Task

Determining readmission cause: no easy task!

- medical conditions more complicated
- social situations more difficult
- fewer resources in the community

Effective transitions are impossible without patient engagement!

- What more can we do?
- What can we control?

Patient Family Engagement

Various uncontrollable factors

- **Readmissions from Skilled Nursing Facilities**
  - Community physicians lacking coverage when they're gone
  - Covering physicians lack of knowledge of the patient
  - Medical management of increasingly difficult conditions
  - Adherence to the POLST or comfort care wishes
  - Families pushing for readmission

Patient Engagement strategies:

- **House call program: Physician assistant /physician program**
  - Patient/family contact and **frequency** of oversight
  - Patients and families **listen** to the PA or physician
  - More complicated medical conditions are **addressed**
  - Increased and more in-depth **conversation**s re: patient wishes

Patient Family Engagement

- **Social workers try to make sure a POLST is completed for all patients d/c to a SNF**
  - To ensure that they communicate the same information to the patient/family that we did
  - To ensure that patient/family wishes can be respected and followed
- **Communication with SNF staff**
  - To prepare them for communication to patients/families
  - Continuity of care and communication
- **Educating patients/families re: the pertinent issues**
  - How to navigate the system
  - Choices
  - What to expect from the SNF compared to the acute hospital

Patient Family Engagement

- **Readmissions from Home Health Agencies**
  - **Uncontrollable factors**
    - Community physicians lacking coverage when they’re gone
    - Covering physicians lack of knowledge of the patient
    - Medical management of increasingly difficult conditions
    - Home Health agency staffing unable to open a case
      - Patient/family refusal
      - Unexpected staffing issues
      - Referral process complications
    - Patient/family refusing a recommended higher level of care
      - Skilled nursing facilities
      - Hospice
      - Caregiver issues

Patient Family Engagement

Patient Engagement Strategies

- **House Call Program**
- **Communication : the importance of Home Health involvement**
  - Home Health RN family meeting prior to discharge on complicated cases
  - Social work involvement prior to discharge
    - Family conference: understand the recommended level of care
    - Psycho-social factors affecting patient/family decisions
    - Handoff Home Health social worker/nursing staff
- **Develop “Plan B” for discharge plans**
  - Home Health/hospital staff cooperation to implement plan B when the home plan fails
  - Continue the Home Health/Hospital Community Partnership Group
  - To adequately address patient/family transition needs
  - To work toward consistent communication with the patient/family

Patient Family Engagement

Readmissions from Home

- **Uncontrollable factors**
  - Medical management
  - Patient/family choices
    - Lack of follow-up with physician appointments
    - Not following medication, dietary, or lifestyle recommendations
    - Psycho-social issues
      - Inadequate help at home
      - Substance abuse
      - Homeless patients

Patient Family Engagement

Patient Engagement Strategies

- Coordination with the community physician/staff
- Pharmacy involvement: Medical practices
- Coordination of care with payor case managers
- **Strong** social work involvement in the hospital
  - Family communication education family conferences
- Transition Social Work
- **Extensive** involvement: Referrals, coordination, and follow-up
- **Extensive** communication with patient/family
- Help with navigating the medical system

Patient Family Engagement

Bundled Payment Process

- Patient Engagement: Coordination across settings
  - Prior to surgery
    - Physician's office
    - Patient Discharge Advocate
    - Patient/family joint education class (Physical Therapy)
    - RN Pre-op appointment
- **Very structured case management**:
  - Patient engagement involves a stronger relationship with patients
  - Patient Discharge Advocate calls 24 hours after discharge
  - Case management monitors pathways
    - Skilled Nursing Facilities
    - Home Health Agencies
    - Outpatient Therapy

The Future

- **Palliative Care Issues**
  - Comfort care issues: Emergency Department or ICU?
  - Bio-ethics Committee: Physician education/support
  - SNF/Home Health Community Partnership Group
- **Poly-pharmacy**
  - Many very elderly people on 20+ medications
- **Level of care refusals**
  - Standardizing an approach

The Future

- **Bundled Payment Growth**
  - More diagnoses/conditions
  - Post discharge structured case management
    - Extend patient/family engagement
    - Medical Practice case management
- **Patient Portal:** Another way to engage patients
  - Access to medical information
  - Potential to e-mail medical practice physicians
  - Potential to make medical practice appointments
- **Strengthen teach back with nursing staff:** The second wave

The Future

- **Patient Perception of Care Survey** (HCAHPS)
  - Nursing communication: top 25th percentile 2013

    Courtesy Respect Listening Explaining
  - Hospital overall rating: top 25th percentile 2013
  - Continue commitment to community coordination
  - Continue efforts to reduce readmissions

Patient Family Engagement

Thank you!